

Public Employees Health Program

Please keep a copy for your records and mail original to:

560 East 200 South, Suite 100 / Salt Lake City, Utah 84102-2004

Customer Service: 801-366-7555 / Toll Free 800-765-7347

State of Utah Medical and Dental Enrollment and Change Form

Section A

Important Note:

Changes made on this form will affect your medical, dental and vision coverages only. If you need to change other PEHP coverages, please complete the appropriate forms for those plans.

Employee and Coverage Information

PLEASE PRINT CLEARLY

☐ New Enrollment ☐ Change Requested (Please specify type):

EMPLOYEE NAME (last, first, middle initial)	SOCIAL SECURITY NUMBER	BIRTH DATE (mm/dd/yy)	MARITAL STATUS <input type="checkbox"/> Single <input type="checkbox"/> Married	GENDER <input type="checkbox"/> Male <input type="checkbox"/> Female
MAILING ADDRESS	CITY / STATE / ZIP	PRIMARY PHONE		
EMPLOYER / DEPARTMENT Did you transfer from another department? <input type="checkbox"/> Yes <input type="checkbox"/> No What department?	ALTERNATE PHONE		HIRE DATE (mm/dd/yy) ¹	
Group Medical (check one) <input type="checkbox"/> Advantage STAR ² <input type="checkbox"/> Summit STAR ² <input type="checkbox"/> Preferred STAR ² <input type="checkbox"/> Advantage Care <input type="checkbox"/> Summit Care <input type="checkbox"/> Preferred Care <input type="checkbox"/> No medical coverage at this time				
COVERAGE TYPE (check one) <input type="checkbox"/> Employee only <input type="checkbox"/> Employee plus one dependent <input type="checkbox"/> Employee plus two or more dependents				
Group Dental (check one) <input type="checkbox"/> Traditional Dental <input type="checkbox"/> Preferred Choice Dental <input type="checkbox"/> Regence Expressions Dental <input type="checkbox"/> No dental coverage at this time				
COVERAGE TYPE (check one) <input type="checkbox"/> Employee only <input type="checkbox"/> Employee plus one dependent <input type="checkbox"/> Employee plus two or more dependents				

Optional Vision	<input type="checkbox"/> EyeMed	<input type="checkbox"/> Opticare E	<input type="checkbox"/> No Vision coverage at this time
<input type="checkbox"/> Employee Only	<input type="checkbox"/> Employee plus one dependent	<input type="checkbox"/> Employee plus two or more dependents	

1. New enrollees, if you have had previous health coverage within the last 9 months, please attach a Certificate of Creditable Coverage from your former insurance company.
2. If you elect to participate in the URS Health Savings Account (HSA), you must complete an enrollment form for that program - which will be sent to you after enrollment.

Section B

Dependent Information ADDITIONS

Complete the table below listing your eligible dependents. If adding a new spouse, please include date of marriage, and copy of marriage certificate. If dependents are stepchildren, natural children not living with both parents, or classified as other relationship please provide supporting documentation, i.e. divorce decree, court orders, birth certificate, etc. If you don't have supporting documentation please explain in Section D.

RELATIONSHIP TO EMPLOYEE	FULL NAME OF DEPENDENTS (last, first, middle initial)	MARRIAGE DATE (mm/dd/yy)	GENDER	BIRTH DATE			DEPENDENT SOCIAL SECURITY NO.	COVERAGE DESIRED
				Month	Day	Year		
CODE KEY	S		<input type="checkbox"/> M <input type="checkbox"/> F					<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision
S - Legal Spouse			<input type="checkbox"/> M <input type="checkbox"/> F					<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision
C - Child Natural / Adopted			<input type="checkbox"/> M <input type="checkbox"/> F					<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision
			<input type="checkbox"/> M <input type="checkbox"/> F					<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision
SC - Stepchild			<input type="checkbox"/> M <input type="checkbox"/> F					<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision
O - Other (Describe in Section D)			<input type="checkbox"/> M <input type="checkbox"/> F					<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision
			<input type="checkbox"/> M <input type="checkbox"/> F					<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision

Are you, your spouse or dependents covered by any other health or dental plan or by Medicare? ☐ Yes ☐ No If yes, complete Section C

REMOVALS

Fill out the table below if you are terminating coverage for dependents who are no longer eligible. If termination is a result of a divorce, a copy of your divorce decree is required.

RELATIONSHIP TO EMPLOYEE	DEPENDENTS TO NO LONGER BE COVERED (last, first, middle initial)	DEPENDENT SOCIAL SECURITY NO.	REASON FOR TERMINATION (i.e. marriage, divorce, death, age of 26, etc.)	APPLICABLE DATE*		
				Month	Day	Year
CODE KEY						
S - Spouse						
C - Child Natural / Adopted						
SC - Stepchild						
O - Other (Describe in Section D)						

*Applicable Date could be date of marriage, divorce, birthday, etc.

Signature required, see Section E.

ST-E

Updated 3 -11

Medical and Dental Enrollment and Change Form (Continued)

State of Utah

Employee Name: _____

Social Security Number: _____

Section C

Multiple Group Coverage

Complete if you, your spouse or dependents are covered by any other health or dental plan, sponsored by an employer or by Medicare.

INSURANCE COMPANY/HMO & PHONE NO.	NAME OF POLICY HOLDER	POLICY HOLDER SSN OR POLICY NO.	EFFECTIVE DATE (mm/dd/yy)	TYPE OF COVERAGE	TYPE OF POLICY	MEDICARE	EMPLOYEE/DEPENDENTS COVERED BY PLAN (Only First Name is Needed)
				<input type="checkbox"/> Health <input type="checkbox"/> Dental	<input type="checkbox"/> Employee <input type="checkbox"/> Retired	<input type="checkbox"/> A <input type="checkbox"/> A&B	
				<input type="checkbox"/> Health <input type="checkbox"/> Dental	<input type="checkbox"/> Employee <input type="checkbox"/> Retired	<input type="checkbox"/> A <input type="checkbox"/> A&B	
				<input type="checkbox"/> Health <input type="checkbox"/> Dental	<input type="checkbox"/> Employee <input type="checkbox"/> Retired	<input type="checkbox"/> A <input type="checkbox"/> A&B	

CUSTODY OF CHILDREN

If dependents listed on reverse side are not living with **BOTH** natural parents, please complete the following:

Who has physical custody of the natural children? <input type="checkbox"/> Mother <input type="checkbox"/> Father	Please provide names and birth dates of both natural parents. Mother: _____ Father: _____ <div style="display: flex; justify-content: space-between; width: 100%;"> Name Birth Date Name Birth Date </div>
Who has physical custody of the stepchildren? <input type="checkbox"/> Mother <input type="checkbox"/> Father	Provide names and birth dates of natural parents of stepchildren. Mother: _____ Father: _____ <div style="display: flex; justify-content: space-between; width: 100%;"> Name Birth Date Name Birth Date </div>

Section D

Explanations

Section E

Employee Agreement and Signature

Before signing, make sure all applicable sections are complete so your enrollment is not delayed. You may be asked to provide additional information and or documentation. Please note: It is the employee's responsibility to notify the Public Employees Health/Dental Program within 60 days of any change affecting dependent eligibility (i.e., birth, marriage, divorce, etc.).

I represent that all information is true and correct. I understand and agree that any false information I provide on this form may, at PEHP's sole discretion, result in a limitation or termination of my coverage. By signing below I hereby: (1) authorize the deduction of health/dental contributions through the provisions of IRC Section 125 Flexible Benefits; (2) authorize PEHP/PEDP to release information to health/dental providers, insurance entities, or other entities necessary to process claims and to administer the Health Plan; (3) certify all dependents listed are eligible for coverage; (4) understand if PEHP/PEDP is not notified that a dependent is ineligible and subsequent claims are paid, I will be responsible for reimbursement to PEHP/PEDP for any claims paid in error; (5) agree to the terms and conditions in the PEHP/PEDP Master Policy.

EMPLOYEE SIGNATURE	DATE
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Please make a copy for your records.